MyHSA HEALTH SAVINGS ACCOUNT
DISTRIBUTION REQUEST

Instructions – This form is used to request a distribution from your MyHSA account. Please do not send any receipts along with this form you will want to keep those for your own records. Any non-qualified distribution could be subject to taxes and an additional tax penalty.

ACCOUNT HOLDER INFORMATION		
Name: (First):	**(MI):**	**(Last):**
Social Security Number:	**Daytime Phone Number:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:		

Distribution Reason – (Check appropriate distribution type and provide requested information):

Will this request close your MyHSA Account? ☐ **Yes** ☐ **No**

There is a $30 closing fee if applicable

Select one of the following:

☐ **Normal Distribution** (for reimbursement of a qualified medical expense) Amount Requested $_____

☐ **Rollover/Transfer** (to transfer balance to another institution or distribution due to death of account holder)

Amount Requested (if less than total balance) $_____

○ Distribution is payable to account beneficiary (provide payee information below).

○ * Transfer is payable to a Qualified HSA (if payable to an HSA administrator provide payee information below).

Payee name: _____

Payee address: _____

City, State. Zip Code: _____

* There is a $30 outgoing transfer fee for a trustee to trustee transfer.

HSA ACCOUNT HOLDER AUTHORIZATION AND SIGNATURE:

I hereby request and authorize Alliance Benefit Group of Illinois to process the above requested distribution from my Health Savings Account. I understand that the funds requested will be delivered to me utilizing standard services provided by the U.S. Postal Service unless I have previously completed the Authorization for Direct Deposit (EFT) Form. I further certify that I understand the requested HSA distribution will be processed as soon as possible following availability of funds and that there may be additional fees (see fee schedule) charged by Alliance Benefit Group of Illinois associated with this distribution. I understand that I am responsible for any consequences resulting from this distribution including taxes and penalties owed. I agree to indemnify and hold Alliance Benefit Group of Illinois and The Charles Schwab Trust Company harmless from any resulting liabilities. I acknowledge that neither Alliance Benefit Group of Illinois nor The Charles Schwab Trust Company have provided me with legal advice and I further agree to consult with my personal tax consultant or legal counsel as I deem appropriate for guidance.

HSA Account Client Signature: _____ Date: _____

Please complete and return this form to:

Alliance Benefit Group
456 Fulton Street, Suite 345
Peoria, IL 61602
Or fax the completed form to 800-688-4329.

If you have any questions please call customer service at 800-57 MyHSA (1-800-576-9472)